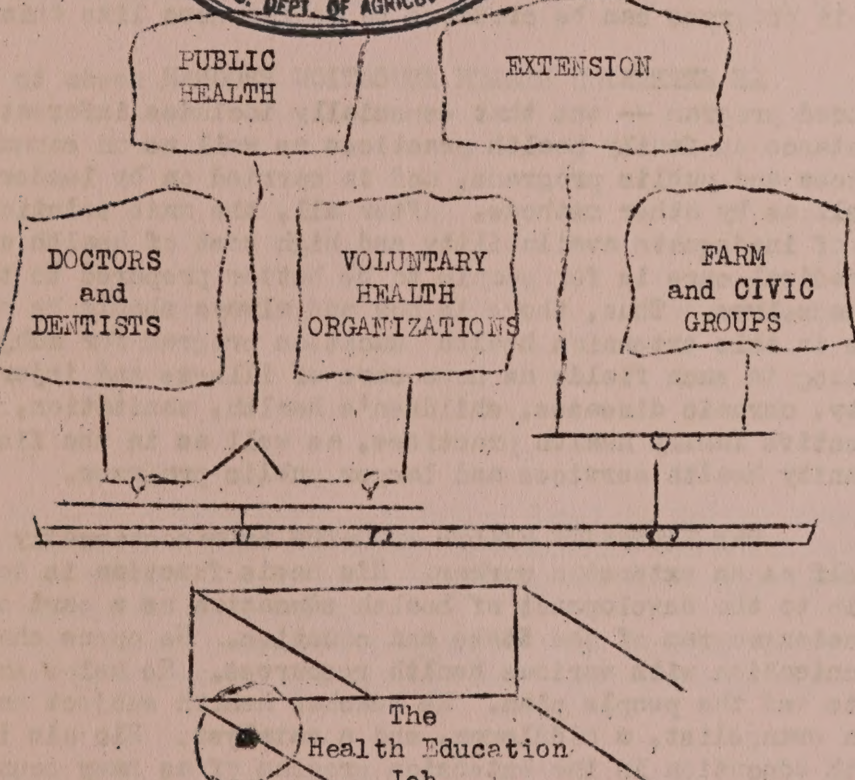
SUMMARY

EXTENSION HEALTH EDUCATION SPECIALISTS' CONFERENCE

Roanoke, Virginia, March 1-4, 1953

"Doing Our Part as a Member of the Health Education Team"



EXTENSION SERVICE * UNITED STATES DEPARTMENT OF AGRICULTURE * WASHINGTON D.C.

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FOREWORD

THE PURPOSE of this and similar previous conferences was to provide an opportunity whereby persons engaged in extension health education might come together for a period of in-service training to obtain new information about rural health problems, exchange experiences about how different States meet their health education problems, learn about new health subject matter and published materials, see demonstrations and exhibits, and confer with resource specialists. This report is provided as a helpful record of the conference for the benefit both of the State extension workers who attended and of those who did not.

PROGRAMS RELATING TO HEALTH have long been included in cooperative extension work. But it is only in the last 8 years that a specialized health education program on a project basis has become generally established. Today 22 States have had such a program, and several others do a great deal in this field through other assigned personnel. It is doubtful if any other new extension program has made such rapid growth in such a short span of years. Health education in the name of health is readily becoming an accepted and integral part of extension work thoughout the country. Much progress can be seen State by State over a 5 or 6-year period when viewed in terms of understanding of the staff, activities carried by county groups, things accomplished, cooperation with the medical people and health agencies, and interest in health on the part of the people themselves. States having projects with specialists have made unusually good progress. Much of this progress can be credited to conferences like this one.

AN EXTENSION HEALTH EDUCATION PROGRAM needs to be a balanced program — one that especially includes information and assistance on family health practices as well as on community health services and public programs, and is carried on by leader training as well as by other methods. After all, the main solution to problems of inadequate availability and high cost of health services and medical care is for people to be better prepared to take care of themselves. Thus, there is now and always should be a large place in this extension health education program for subject-matter teaching in such fields as home care of illness and injuries, home safety, chronic diseases, children's health, sanitation, and other preventive family health practices, as well as in the fields of community health services and larger public programs.

THE EXTENSION HEALTH EDUCATOR tries continually to develop himself as an extension worker. His basic function is to give leadership to the development of health education as a part of the total extension program of the State and counties. He opens channels of communication with various health resources. He helps extension agents and the people plan. He teaches health subject matter. He is an evangelist, a middleman, and a catalyst. His aim is to develop health education in the extension program of as many counties as possible and help them reach as many rural people as possible with it. And in all this he is guided most of all by the policies and conditions of his own State extension service and situation.——E.J.N.

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Prepared by E. J. Niederfrank, Extension Service, United States Department of Agriculture and Helen L. Johnston, United States Public Health Service, from the notes of conference recorders with some additions and editing.

Distribution: State extension directors, home demonstration leaders, health education specialists and rural sociologists.

ENROLLMENT AT CONFERENCE

State Extension Personnel

Arkansas	Helen Robinson, extension health education specialist
Florida	Frances Cannon, extension health education specialist
Georgia	Lucille Higginbothan, extension health education specialist
Illinois	Pauline Brimhall, extension health education specialist
Indiaia	George Nuffer, extension health education specialist
Iowa	Merl Wherlow, extension health education specialist
Louisiana	Florence Abington, extension specialist, family life and health
Michigan	David G. Steinecke, specialist, health and safety organization
	Paul A. Miller, extension rural sociologist
Mississippi	Annette B. Boutwell, extension health education specialist
Nebraska	Helen L. Becker, extension health education specialist
New York	Blanche Armstrong, extension health education specialist
North Carolina	Jewell G. Fessenden, extension specialist, nutrition and health
Ohio	Guy Dowdy, assistant program supervisor, Extension Service
Oregon	Mabel C. Mack, assistant director, Extension Service
Pennsylvania	Mary K. Rissinger, extension home economics supervisor
Puerto Rico	Rosa Odonez, extension health education specialist
Virginia	Maude E. Wallace, State home demonstration leader
	Janet L. Cameron, extension nutritionist
	Hallie Hughes, assistant State 4-H Club leader
West Virginia	Gertrude Humphreys, State home demonstration leader
Wisconsin	Edith Bangham, assistant State home demonstration leader

Resource Persons and Participating Guests

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Elizabeth Lovell, chief, health education, N. C. State Health Department
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Charlotte B. Rickman, health education specialist, N. C. State Medical Society
Thomas E. Roberson, health education consultant, U.S. Public Health Service
Margaret R. Svoboda, Roanoke County home demonstration agent, Salem, Va.
Kenneth Williamson, vice president, Health Information Foundation, New York, N.Y.

SUMMARY OF
EXTENSION HEALTH EDUCATION SPECIALISTS' CONFERENCE
Roanoke, Virginia, March 1-4, 1953

SESSION 1 - ARE WE ON THE ROAD WITH THE TEAM?

A. Benefits of AMA Rural Health Conference for Extension

This part was conducted as general group discussion led by Annette S. Boutwell, of Mississippi, and Merl Whorlow, of Iowa. The following were listed as among the main values and outcomes of the AMA rural health conference for extension health education:

1. Contributes to the building of closer working relations among various groups and agencies concerned with rural health, especially among the professional medical people, farm organizations, and health educators.

2. Furnishes opportunities for exchange of information concerning problems and activities in many States. Stimulates the idea of having State rural health conferences as a form of health education.

3. Stimulates awareness of rural health problems, especially those pertaining to getting and using doctors.

4. Provides case stories of examples of ways to solve community health problems back home, particularly problems of adequate medical personnel and health services.

B. Rural America's No. 1 Health Problems

This was the main part of Session I and was opened with an address by A.L. Chapman, M.D. 1/ This was followed by a panel discussion and general group discussion. The major rural health problems brought out by Dr. Chapman and the discussions are listed below:

1. The chronic diseases -- more adequate diagnosis, care, and control. (Chapman)

2. More adequate health facilities and services, with particular reference to the chronic diseases. Health facility needs include prevention and curative services, local health departments, community hospitals, and regional teaching treatment centers. (Chapman)

3. The difficulty of meeting costs of health and medical care, especially for emergency cases and instances requiring major attention. In this field of payment, needs include extension of voluntary health insurance, efficient and effective medical care of the indigent, and generous support of community chests and other programs. (Chapman)

1/ Regional Medical Director, Region 3, U.S.Public Health Service

4. Need for establishing a foundation of good health during preschool and school days, since good health at 5 or 10 years of age is more likely to lead to good health at 65. This need includes the building of good eating habits among young children and their teaching by parents.

5. Overweight — this is the No. 1 nutritional problem today, especially since it is related to so many chronic diseases and other illnesses and since we are having an increasing proportion of aging people in our population.

6. More doctors, better distributed.

7. More effective use of existing health facilities and services. There is a great need for people to know better what they already have and to develop good attitudes toward the use of available health resources.

8. Accident prevention. We need to appreciate more the importance of preventing accidents particularly in the home, in order to reduce the costs of treatment and rehabilitation, and reduce deaths from accidents. Accidents are a main cause of deaths among children.

9. Mental health — its importance and the development of proper knowledge and attitudes toward the use of mental health services. Personality maladjustment, including mental illness and disease, has been on the increase in this country. Yet at the same time we know more than ever before about the development of better mental health and personality. We need to get this information and newly established later information to the people.

10. The need for better understanding of the scope of the whole medical care problem. The majority of rural people think of it in terms of seeing a local doctor or going to a hospital in case of extreme illness or to get a particular condition cared for. There is a great lack of appreciation of preventive medicine and health practice and a lack of information about it. We also need to develop a greater consciousness of what preventive health is; for example, to eliminate the fear of having a physical examination that might find something wrong and fear of costs that might reduce family living standards.

11. A basic element in meeting many of these needs is more effective health education. We continually need to use improved methods and organization. We need to dispel misunderstandings about health. We need to provide more information for the individual which will enable him to establish in his own mind the relation between health and sickness and his responsibilities toward them — for himself and for other members of the family.

12. Specific needs and problems in relation to health education were also listed, as follows:

    a. Better understanding of how to evaluate needs and help the people decide upon the best courses of action.

b. How to avoid starting on the fringes of problems and continuing to concentrate on the fringes, rather than getting at the heart of health problems concerned. Too often people are likely to think in terms of patching up after an accident. There is a need for families and communities to lay plans for solving long-term problems as well as meeting emergency or current conditions.

c. How to get coordinated action or teamwork on the local level among the many of interested groups or agencies. Can we increase our skills in working together with organizations and related groups? How can we as professional workers submerge our professional interests for the time being in order to help people develop a program from their point of view and which is of, by, and for themselves?

d. We need to avoid extremes in our approach and also avoid too fast progress. We need to avoid both the "tell 'em" method and the "let them pool their ignorance" method. We need to start with a small unit and work up and not with the State or county level and work down. However, this does not necessarily rule out State and county leadership, but it does say that the approach should be people-centered and locally centered. We also must recognize the need for working with different people in different places with different resources and with different socioeconomic situations on different local problems.

e. Motivation is a No. 1 problem in health education. What appeals can we use to lead people toward to be healthy, to want to adopt recommended personal and family health practices, to want to have a health department, to want to work together with others?

The opinion was expressed that extension's adult education-program solving philosophy and technique probably holds the main clue to solving rural health problems. Situations for self-motivation need to be set up or capitalized upon wherever they are found. Interpretation of services must be in terms meaningful for the local family and community. The fact that value systems differ must be recognized. Common understanding among health agencies or specialists is also an important step before trying to develop understanding among others.

In emphasizing the chronic diseases as a major problem common to both rural and urban populations, Dr. Chapman said that 80 percent of deaths at present are due to cardiovascular conditions and cancer. About 1950 a turning point was reached between two eras -- the era of acute diseases and the era of chronic diseases. He said there are several factors that make chronic diseases important and are resulting in new attitudes and relations between public health and professional medicine. These factors are:

Chronic diseases last longer.
Care of chronically ill patients costs a lot more.
Chronic diseases affect earning power.
Chronic diseases bring unduly heavy financial burdens, disrupt family life, contribute to poor mental health.
Early diagnosis is difficult.
Treatment aimed primarily at preventing progression rather than complete and permanent cure.
Long period of chronic diseases suggests importance of unearthing them early in their development.

"Chronic diseases involve a need for continuing medical supervision over a relatively long period. They may require extensive rehabilitation. They involve the need for paramedical services (that is, services of auxiliary medical workers like technicians, dieticians, therapists, social workers, and others) as the scope of public health and medical care broadens. They require expansion of public health and medical knowledge and demand a continuing type of professional education in order to keep up. The increasing prevalence of chronic disease that never really is cured is multiplying demands upon physicians. Private physicians and health officers are becoming more willing to admit that many services they have rendered can be done by others.

"The outlook for many cases of chronic disease is also determined by economic and social factors. The cost of providing adequate care is likely to rise. How can ways be provided to pay the larger bill? Until we are willing to pay for services that are potentially available, they will not be made available in adequate quantity. How can more of all types of health services be brought to the people?

"The American Hospital Association and American Public Health Association have recommended the organization of local health units and to relate them to hospitals in order to provide a comprehensive system of health service. This is being experimented with in an increasing number of communities. So also is the affiliation of the local hospital with the larger regional hospital. The affiliation of hospital and health department enables joint use of facilities, with outpatient services developed by the hospital using the same facilities the health department uses toprovide chronic services.

"Today, less than 5 percent of cities with 100,000 or less people have outpatient services, which means that many people are paying the high cost of hospital service for chronic disease care that might be rendered on a cheaper basis nearer home.

"The affiliation of the community hospital with the larger hospital also provides opportunity for continuing education. Follow-up of chronically ill patients is made more certain and more effective if activities of the health department and hospital staffs are closely related. The existance of the community medical center facilitates group practice. More services can be rendered by the individual in a group than by the individual practitioner. The community medical center serving as a diagnostic center may be used to provide diagnostic services for multiple screening purposes. The medical center may also house individual physicians as well as physicians engaged in group practice.

"How can the gap between the community medical center and the family on the farm be bridged? One way is through mobile screening teams, at the county fair, and elsewhere where people gather. Community screeing programs might also be initiated in the schools, as nearly all rural families have some connection with their school. Neighborhood visiting days of the people to their community health center might be another possibility. Special functions like vaccinations, immunization of children, and cancer education are more and more becoming organized to include rural people.

"Much progress is being made. There is still much progress to be made.

"When we have done all these things, we will have to pay for them in many ways — through increased contributions to voluntary health insurance plans; by increasing the community's contribution to the medical care of the indigent and to health department operations; by a more generous support of local hospitals; and through increased contributions to voluntary health agencies.

"Perhaps the greatest price we will have to pay will be the subordination of our own personal interests to the interests of farm people, without whom all of us soon would go hungry."

SESSION II - DOINGS BY OUR PART OF THE TEAM
Brief Reports From States

This session consisted of a report of current extension health education activities from each State represented. The highlights of these brief State reports (limit 7 minutes) were as follows:

Arkansas

A major activity was the second annual State rural health conference. More than 500 persons attended, 60 percent of whom were farm people. Conference sponsored by Arkansas Medical Society, medical auxiliary, dental association, extension service, farm bureau, home demonstration clubs, and others.

Another major activity has been helping our community improvement clubs on health. Incidentally, they have done more to arouse men's interest in health than anything else. Focus of efforts is on home improvement, agriculture, community activity. About 200 communities are organized. They use flip sheets to stimulate discussion at community meetings. Some counties have made their own.

Health planning and leader training with the home demonstration and 4-H groups are also carried on, mainly on family health practices. We have two demonstration county developments. One is on water supply. The men learned how to take samples of water, then went back home and did so, and the water was tested by the State health department. Then, when the reports were received, follow-up meetings were held to explain them and plan well corrections. The other county demonstration is on how to develop a health council.

Florida

A new project this year. We have had organized State extension health program only for the last 6 months. First 3 months spent in convinving State home demonstration staffs that there was something to health besides nutrition; then 3 months spent convincing county staff of same thing.

State extension health committee formed, including nutrition, home improvement, marketing, health education, food conservation, and other interests.

Am preparing material that will help open up some possibilities for enlarging health aspects of 4-H and home demonstration work. These include check sheets for 4-H and fact sheets for local chairmen of home demonstration clubs.

Leader-training meetings requested by 47 counties (26 meetings altogether). Mainly on health planning and family health practices. Am trying to show how health fits in with total extension program.

At Farm and Home Institute we had an address and discussion by a doctor who gave the local doctor's viewpoint. He tried to develop understanding of the training he is required to have, why he charges the fees he does, what is included in a health examination, understanding of his liking to be at home with family too rather than working beyond regular office hours and making home calls.

Georgia

Georgia Citizens' Council comprised of lay and professional representatives was started about 6 or 7 years ago.

Extension service tries to divide time so that all 159 counties will get some help during the year; each specialist on home demonstration staff will work in a number of counties in each of the six districts during a year. Counties are divided into three groups: Emphasis, preliminary, and followup.

Civil defense is being worked in with home safety program.

Extension's objective is to get health into county agricultural programs; relate health to other projects.

Objective: To learn what county resources are, including prepayment plans, and to learn what county needs are. Work through county and community groups.

Illinois

Staff planning meeting selected three major health problems to work on: Safety, weight control, and brucellosis.

Accident prevention program started about 10 years ago by State Extension Service in cooperation with the State Home Bureau. Now are getting report of nonfatal home accidents as well as others. Taught by leader training in many counties.

Weight control is joint nutrition and health education project, carried on jointly with State department of health and State medical society. It is being developed on a pilot county basis first. Objectives are to reemphasize adequate nutrition, point out advantages of weight control, face the fact that excess weight is a health hazard and that reducing diets should have basic elements. Planning is at county level. All planning with editorial staff, radio and television, open forums, and farm and home week program. Materials to be prepared by committee of nutritionists, public health people, extension staff, and others. Leader training in Home Bureau units.

Our State legislation requires that all dairy herds be free from brucellosis by January 1, 1955. Public health and various extension departments are cooperating to this end. We have a program going in three pilot counties — one with a health department, one with city health department, and one without a health department. Record and analysis of progress in each being kept. Kits of materials will be prepared for additional counties. Work to be done on township basis. Numerous planning and teaching meetings have been held. Health education specialist prepared a preliminary leaflet on human health aspects from which other leaflets are being developed. Trying to keep a family approach in the education program as much as possible, not just a men's or agricultural program. Opposition to the idea is beginning to be felt because of the high percentages of infected herds and of animals in herds.

Community health is also worked on, mainly through talks and planning with the county health improvement associations (Blue Cross-Blue Shield). Home Bureau leader training lessons are also given to numbers of counties on Know Your Heart, Home Care of Ill, and other topics. The specialist also teaches a one-semester course in home nursing to college home economics students.

Indiana

Health specialist is joint employee of State health department and extension. So we rely on nurse and health educator in each district public health unit, and easy for me to do so.

Major work in extension is with extension home economics, - 4H, and community organization programs. Leader-training meeting requested by 29 home economics clubs last year, 4 of which were taught by the health specialist (others by State health department cooperation).

A rural health section is held each year in connection with our summer agricultural conference. One day will be devoted to health this year.

Preparing a guide on health and safety for 4-H this year. Will include sanitation, good grooming, farm safety, and other topics.

Have 34 county health councils in the State. About 35 to 50 percent of them are doing a good job. Specialist taught health with extension caravans, farmers' institutes, or extension schools in 27 counties.

Prepared a State fair exhibit.

Helped with four regional health conferences of State health department.

Problem: County agents are trained in farm economics; no training in health. I suggest a one-semester course in rural health plus in-service training for county extension workers.

Iowa

Trying to get more health into 4-H programs, especially in boys' groups.

About 1/3 of counties have health councils. We do not try to organize new ones, State health department does this. Giving attention to helping those already organized do a better job.

Health improvement associations now in many counties. They are interested in becoming more than a sponsoring agency for Blue Cross and Blue Shield; interested in health education and improvement. I help them on planning.

We meet with many county health planning groups, especially in competition with home demonstration work.

Many communities are becoming interested in health resource and need inventories. List what they have and what they need.

County family living groups assist in planning at county level. Health chairmen need help in knowing what to do.

Work with other extension specialists in training agents to do the health job; many agents are not familiar with health problems and programs.

Agents have asked that human health be included in publications of other specialists; for example, human health aspects of brucellosis control need to be emphasized as well as economic aspects. Are doing much on brucellosis; much more needs to be done.

Louisiana

Parish (county) surveys made by agents.

Health chairman in State home demonstration council. She makes recommendations to State council, and parish chairmen follow through on them.

Serve on health council. Holds a 2-day conference annually for exchange of information. Includes home nursing, Blue Cross and Blue Shield, and other subjects.

Work with Louisiana Heart Association. Home agents work with cardiac classes on how to live with heart conditions and still be an efficient homemaker.

Have a group therapy project on weight control with public heart department tackling some emotional problems.

Work on mental health, through my work also as family life education specialist.

Prepared a lesson, using "chalk talk" on mental health and personality.

Michigan

Lenawee County survey illustrates the principles that you should start with people where they are and lead only as fast as they will follow. Work is still progressing toward a published report. County school superintendent is new president of county health council there. Planning a banquet sometime late in summer or early in fall.

State rural health conferences held at college in January; counties involved through questionnaire circulated before conference.

Have aided many county and State groups on health planning, including county health councils and AMA members of State rural health council.

PTA group is interested in mental health in connection with community development.

Produced a television show on safety from which a kinescope was made for use in State.

Have prepared series of 4-H pamphlets on health and safety. Also serving on the National 4-H Health Committee.

Mississippi

Concentrating effort on helping health planning through the new community improvement club program. Am getting more requests from district and county agents than ever before. Have had 13 agent-training meetings on health. Each community improvement group has a health committee. The community development program is helping get the men involved in health activities.

Have about 300 organized communities with both men and women included. About 80 percent of groups report interest in health, but only 5 percent have had programs in health so far.

Negro agent association now has a health com ittee which has organized a program and sent it to every county.

Have put 4-H health on a project basis with an awards program sponsored by a life insurance company. We have worked hard on the preliminary plans, county planning, agent training, and in preparing teaching materials.

Trying to involve additional agencies and professions with the aim of setting up a State planning body later.

The Delta Council — 18 counties — has carried on a campaign against VD for about 10 years. Schools, health departments, extension agencies, vo-ag teachers, and others have cooperated.

Nebraska

Have aided a pilot program on safety in one county with the county agent as the leader. This has been under way for 3 years. Another county also has a safety program.

A bulletin What Nebraska Homemakers Are Doing About Home and Farm Safety, is being prepared by homemakers and county agent.

Much of program is taught by leader training in home demonstration groups. Have projects on nutrition — low-calorie diets and weight control — household insects and their control, animal diseases, public health, and prepayment plans.

A survey of medical care and health facilities is being undertaken in the State as part of the Northern Great Plains survey in which six States are taking part. Data being collected from every county of Nebraska and from State agencies.

A pilot project in 4-H health is going on in one county with the county agricultural agent supporting it. More scholarships are available for 4-H in health and safety than in any other field. This is becoming a problem.

New York

Main responsibility--to keep channels of communication open between rural groups and health agencies and to interpret needs of rural people to health organizations and agencies.

Have State extension staff committee at college. Committee determines emphases and plans special projects such as health part of Farm and Home Week.

Meet with the 4-H agents committee on health. Under the leadership of this committee, specialists is preparing a filmstrip on the physical examination for club use, and a health project book containing lesson guides for several topics on health and a project record form.

Have 47 county health and safety committees; some have been active and others not. Specialist helps them in health planning upon request, then follows up with needed materials or suggestions.

Developed health directory to be adapted by local leaders; this has been one of best tools for getting people to look at what they have and what they need. Panel of local agency heads are meeting with local groups in some areas to intrepret their services.

Have worked on civil defense and home preparedness programs with district and State groups.

North Carolina

Health is part of all extension programs and agricultural planning. In a number of counties health is a major goal. We give aid to their health planning by presenting facts, helping discuss facts, and relating them to resources.

State health department, State department of welfare, and State tuberculosis association cooperate. Problems to be worked on, aims, what home agents can do, what local health leaders can do, and what the tuberculosis associations can do, are developed cooperatively.

At State level having good working relations. In counties, we don't worry about coordination. If we have a problem, we get together and work on it.

In teaching agents and leaders, provide information about what is good optimum health, what is needed to get good health, and what values are -- economic and esthetic -- that may motivate people to want health.

Work through health chairmen of farm organizations, 4-H groups, and others. Have six district health chairmen. Meet to decide on major suggestions that may or may not be accepted by counties.

Supply teaching materials. Feel that the big job is helping local people to identify and use local resources and to see health as an individual, family, and community responsibility.

Cooperate in planning and conducting State rural health conference.

Home demonstration clubs have helped to get doctors and hospitals and to develop ways to maintain them.

Ohio

Health organization has been our main emphasis the last few years. Extension is active in the Ohio rural health council, which was organized 12 years ago; 22 organizations represented and 22 elected representatives by lay people of State; one-third of these elected and each year for 3-year term. Concentrate on two things: Information to the public and leader training. The latter involves a great deal in extension.

Seven district health meetings this year for purposes of informing public; focusing on animal diseases; living with danger (atomic energy); and other subjects. Extension had a large part in planning and conducting; 55 to 100 or more attended each meeting.

This year a workshop sponsored by the council will be held to train leaders to put on better rural health programs. State council will pay expenses of rural people elected locally to attend meeting.

Columbiana and Clinton Counties continue to work on health improvement following up their self-studies. Various other counties or communities have stuided their situation to some degree as a basis for program planning.

Much cooperative work with the State department of health.

4-H program has project material on health, including a certain degree of mental health or personality growth.

Oregon

Have had three annual State rural health conferences. Extension helped plan and conduct.

A State rural health council was developed from the first conference. Represents all agencies and groups interested. Helps integrate work of participants and keep them informed.

Council is developing a health services guide which will be useful for county offices and other interested persons. Includes information on agencies, what they offer, who is eligible, and how to apply for services. Plans are also being made for regional health conferences throughout State in order to involve more rural people.

Extension has worked with other organizations, including Grange, Farm Bureau, Governor's Conference on Children and Youth, hospital association.

A State agricultural planning conference was held in 1952. One committee devoted its attention to rural life. It was divided into four subcommittees with one on health and safety. Discussions were by rural people using agencies as resources.

Having a county planning council in every county with a home and rural life committee in each. Try to get each committee to select one problem to work on. As a result, they often set up a county health council to involve others. One county worked together to get a county health unit. They had previously decided to make a survey and got Dr. Yantes from Clinton County as a consultant. The State health department is working closely with them.

In all instances a county plan has been developed.

Some communities have needed a great deal of help in developing understanding of the Hill-Burton program so as to obtain community support for needed hospitals.

Focus of one county is prepayment and getting health facilities. They are now 80 miles from the nearest hospital and have deep snows in the winter.

Home demonstration clubs are making a study of existing health services in some counties as a basis for making more use of them and of filling the gaps.

Pennsylvania

State is now bringing in health in joint extension programs to reach both men and women. Health aspects of various extension programs, like weight control in nutrition, are being emphasized more. Much on mental health in family life education programs. Health facilities and services are included in community planning activities of extension rural sociologist.

Materials and suggestions are prepared for county homemakers' days; for example, what services do our voluntary health organizations provide for the community? What clinics are held in our country? What does our community need?

State has a State health council and many county councils. Extension participates in these.

No organized health education job is yet being done by Extension, but hope to have an extension health education specialist soon.

Puerto Rico

Have had an extension health program for 6 years. Health and hygiene is the project. After working on different projects and programs in different places for a number of years, have now decided to embark upon a unified community living and health program in a positive systematic way. Doing this in several pilot counties first.

Have a State coordinating committee for the agencies working on health. Committee meets once a month. Includes extension service, health department, education, school of medicine, tuberculosis association, heart association, Red Cross, and other groups.

Plan in the community health program to work on control of intestinal parasites and other sanitation. Program has been started in three counties. Work starts with a meeting of representatives of interested agencies and interested individuals. This is followed by leader training and a survey by leaders who fill in a blank on housing and environmental sanitation developed by the department of health. As a leader visits a home for survey purposes he or she at the same time does some simple health education. We trained the leader enumerators on this beforehand. Extension and department of education will cooperate in the educational work. County agent and sanitary engineer will visit each house to see where latrine should be placed; for example, part of cost of building will be met by department of health for those unable to pay.

Methods will be tested in the 3 counties to see whether they can be applied in the 76 counties of Puerto Rico. The survey is a technique for involving and motivating the family. All extension programs and agents fitting into the overall approach on health.

Virginia

Health strong in home demonstration work. This year 47 out of 90 counties selected health as a major goal; more worked on arrangements for health examinations than any other one thing. Many worked for improved health facilities and on safety in some counties. In each county, one thing is selected to focus on.

Health project for 4-H members was "Food for Pep." 4-H health is being set up on a project basis, with a leaders' guide and other materials. Promoted lunchrooms in schools where there was no regular lunch program.

Women's groups have promoted health units, trying to get doctors and reach other objectives through local units of State health council.

Public information meetings are held just before legislature meets, and health matters are often brought up for business and recommendation.

Greatest weakness in Extension's health program in State is opinion that health is women's work. Need to get men of the family to consider that health of the family and community is their responsibility too.

West Virginia

Extension cooperates with State medical society in holding a State rural health conference. Employment of an extension health education specialist has been supported by this conference and other groups. So far this proposal has been turned down in drawing up a budget.

We have a State extension staff health committee. Gives guidance primarily to 4-H health work. A number of leaflets have been published. These go out to all clubs. Emphasis last year was on "Come Clean, Go Healthy."

The idea of county health councils is being promoted by certain agencies and extension helps the councils on planning and in other ways.

State and county demonstration leaders' groups consider health and give leadership to local group activities. Many have aided with getting doctors, hospitals, school lunches, sanitation, and other improvements.

Extension nutrition program is giving special emphasis to weight control.

Wisconsin

State has a public health council which is now in its fourth or fifth year. It is working with counties and local groups on surveys. Extnesion participates.

Farm and Home Week programs include emphasis on health.

A workshop for local health councils is planned for May 1953.

Extension also has a big part in the annual State rural health conferences. The council is one of 55 cooperative groups in putting on these conferences. Have meant much to the stimulation of concern in health and health improvement.

Have a State extension staff health committee including administrative people, 4-H, rural sociology, farm economics, dairy production, and others. Gives leadership to extension participation in various programs and to the development of teaching materials.

Work with State migrant committee and Governor's Conference on Children and Youth.

Are developing 4-H Club leaflets on safety, water supply, and other subjects with cooperation of extension agents, local leaders, health department, and medical society. Some excellent materials have already been prepared jointly, such as the first aid guide hang-up for home use.

Summary and Comments

Concluding the reports of the States, H.M. Dixon 2/ commented on progress made in the development of health education in extension during the last few years. He said that "From the beginning, extension has been engaged in various phases of health work. The variety of subject matter covered and the variety of agencies and organizations with which working relations needed to be developed led the Extension Service to feel a need for an across-the-board program. Accordingly, Elin Anderson was added to the Federal staff in 1947.

"Across-the-board programs such as health and public policy are harder to get organized and developed than some other types of programs. A great deal of administrative and supervisory help is needed for such programs. The health program also calls for much building of relationships with other agencies and organizations.

2/ Chief, Division of Agricultural Economics, Extension Service, USDA

"It is important to tie the health program into land-use planning and the regular extension program planning. The setting up of local health services and facilities is directly tied up with use of land and the economy of the area. Some areas will never have what they need until they bring in some small industries or some other source of income.

"Health needs to be tied in with all fundamental planning and policy-making on the county and community basis. The agricultural economist, sociologist, home management people, nutrition specialist, and others have important places in this. None of those should dictate the health education program. Miss Anderson was careful to avoid becoming entirely tied in with and dictated to by other interests.

"While the health education specialist must have a close tie-up with the administrative staff and with other agencies, he must also have broad leeway and a definite program distinct from others.

"The reports of the States just heard show that tremendous progress is being made. I want to congratulate you on what you are doing. The Federal Extension office is back of the health education as a program and we will continue to help you all we can."

SESSION III - METHODS FOR OUR WORK ON THE TEAM

A. Perception and Changing Behavior

Dr. Derryberry 3/ opened a discussion of methods of health education by a problem census, listing some of the problems that specialists encounter in their work. This was followed by a perception demonstration, 4/ further discussion, and a summary by Thomas E.Roberson, 5/

Resistance to change and differences in perception of a situation were clearly brought out as problems, in the problem census, the demonstration, and the discussion. The need was brought out for maintaining a relationship between leader and group that will inspire confidence and promote the ability to work together in defining problems and development methods to solve them.

The perception demonstration and the responses for the group were a striking example of the fact that the only constant factor in a learning situation is the given item of information. Even though one then discovers the real facts and then is faced with the demonstration again from another view it is hard to believe the facts that you know to be true. When information is given to a group of individuals, they each respond in a somewhat different way, each makes a different interpretation, and each has a different situation in which to make application. We must see what we are saying and doing in light of the way the other fellow sees it.

3/ Chief, Division of Health Education, U.S.Public Health Service

4/ Demonstration available from Institute of Associated Research, Hanover, N.H.

5/ Health Education Consultant, Region III, U. S. Public Health Service

Real learning is more than just information-getting. It involves structuring and seeing relationships. It is a result both of what the learner does with the information and of what the information does to him.

In an attempt to bring about changed behavior on the part of either an individual or a group, consideration needs to be given to the following (Roberson):

1. The beliefs, attitudes, feelings, opinions, and facts the individual already has regarding the new action he is being asked to take (perceptive structure).

2. The needs, goals, and values the individual already has (motivational structure).

3. The controls such as money and other factors, held over his present behavior (behavioral structure).

The extent to which we will be able to stimulate change depends to a large degree upon the extent to which we will be able to modify or change these structures in some particular way. Using the following approach would seem likely in some way eventually to result in some sort of desirable change in behavior (Roberson):

1. Make sure that the requested new action has some real meaning to the individual. If it doesn't, it will not even be considered by him.

2. Once it "makes sense" in some way to the individual, a new action must be accepted by him as a part of his belief, attitude, and feeling. (These tend to protect one from any undesired change in behavior.)

3. An individual must see this requested new action leading to some goal which <u>he</u> has. (<u>His</u> goals and not ours are important to him.)

4. The more of his goals attainable by him, the more likely he is to accept a requested new action.

5. If this requested new action is seen as not leading to his desired goals, he is not likely to accept it.

6. If he can see his goals being reached by some other means which are cheaper, nearer, easier, and less painful than the requested new action he is not likely to accept the new action.

7. The individual must be led to a point where he makes his own decision whether he will or will not make the change.

B. Health Education on Radio and TV

Kenneth Williamson, of the Health Information Foundation, reviewed the various means used by the foundation for getting information to people. An estimated 145 million people receive the daily and weekly newspapers and house organs to which its press releases are sent. The foundation has free time over three nationwide hookups. It can reach an average of 34,000 people per broadcast at an average cost of $7.86. Bulletins, booklets, and pamphlets are sent to a mailing list of 100,000 people — thought and action leaders — including bankers, members of the health team, labor

and church leaders, farm organizations, and others. It costs $45,000 a year to send 6 issues of the bulletin. A questionnaire sent to determine the usefulness of the bulletin to those receiving it elicited an 11-percent response. Business executives show very low interest. Community chests and service clubs showed a more favorable response. Only 298 out of 1,000 health councils reported that they wished to continue to receive it. The highest interest was shown by health professionals — a very small percentage (5 percent of the total list).

The foundation's experience with television has proved costly and full of problems. Promotion is extremely difficult. About 58 stations are now using the 6 films so far produced for television. ABC took them first. Now NBC has arranged for 27 stations on "women's time."

The foundation is at present financing four health insurance studies growing out of 18 months' discussion with Blue Cross, Blue Shield, and commercial insurance. These studies mainly deal with:

1. What are weak spots and how can they be filled?
   What kind of health insurance do people want, and what are they willing to pay for?
   What is the effect of health insurance on family use of services?
   (Clyde Hart)

2. How effective is voluntary health insurance?
   Survey of 3,500 representative families that have insurance — what is the effect of insurance on those families?
   (Catastrophe among low-income groups may not be the big difficulty but rather the constant drain of continuing expenses.)

3. Study of three communities where the local government, medical profession, hospitals, and prepayment plans will get together and cover everyone in the community:

   To bring in indigent.
   To bring in those 65 years of age and over.
   To bring in low-income groups.
   To bring in self-employed and farm groups particularly.

   In these communities, the foundation will provide research teams to follow through and find out what happens.

4. Study of debts.
   Using the Federal Reserve Board's sample, the foundation is trying to determine whether the debt was because of illness or because a family wanted to keep its automobile, television set, or other expensive items.

The discussion indicated that a number of States are now using television in the extension program. Iowa has weekly programs sponsored by the medical society. One of these dealt with rural health, with the Extension Service, Farm Bureau and other groups participating.

North Carolina has had a demonstration on Milk for Health put on by 4-H girls. Ohio, with the sponsorship of the medical society and public health, has compared health situations in other parts of the world with the situation

in Ohio. A drama team from the university was used. Preparation is costly in terms of time used. Illinois extension has been thinking about health education on television, but so far has not adopted it. Other State and National agencies located at Chicago, like the AMA, are already doing much. Michigan State has had some health and safety programs on television. Experience has shown that the preparation time is enormous. The total effectiveness of television education is not known. Some think it is a boon and will be greatly expanding. Others feel that it is still in its infancy and also that it will never produce very much in the way of lasting results as far as education-learning-adoption of practices is concerned.

C. Home Safety Demonstration

A safety demonstration, including exhibit of many materials and displays, was put on by Kathleen Devine, of the Metropolitan Life Insurance Co., to illustrate some of the common hazards found in homes. It was pointed out that 4 million persons are injured in accidents each year, many of which occur in the home.

Many kinds of home accidents — falls, burns, poisoning, and cuts — were illustrated by clover charts or devices, and methods shown or discussed as to how these hazards might be eliminated. Members of the audience had opportunity to examine the items for themselves and discuss them with the demonstrator. This proved an effective way to emphasize the points made. Several States indicated a desire to obtain Mrs. Devine's safety demonstration for use at State planning conferences or at Farm and Home Week.

SESSION IV - HITCHING UP THE TEAM

A. School Health

Dr. Donald Dukelow, of Bureau of Health Education, American Medical Association emphasized the need for unified activity on the part of agencies and organizations in dealing with problems of child health with particular reference to schools. The National Education Association and the American Medical Association have been cooperating in conferences, preparation of materials, and other ways for a number of years.

A good school health program involves health education, health services, and a healthful school environment. Health services require the pooling of resources of doctors, teachers, health department, and others. Cooperation provides an opportunity for exchange of information leading to proper care of the child and adaptation of the school environment to his particular needs.

The formal program for health appraisal requires at the minimum one physical appraisal on school entrance and at the maximum, an annual physical appraisal. Probably a realistic program would include one appraisal at school entrance, one at puberty, and one at time of leaving high school. Less frequent and more thorough examinations are more effective than the cursory annual examinations.

B. Community Organization and Methods for Health

This part of the program was concerned with discussion of ways to include health in the programs of community improvement clubs and other community organizations. Community improvement clubs are particularly important in the South at present. For example, Mississippi has nearly 300; Virginia 100; Arkansas 200; Georgia 400; Tennessee 800; Oklahoma 300; and North Carolina 300.

Main conclusions reached are listed below. Some of these apply to this community improvement club type of program and some apply to all types of community health organization work.

1. The health education specialist should first build up good rapport with county agents. His only real entree into a county is through them.

2. He should help create interest and demand especially by familiarizing agents with the health program as a first step toward reaching local leaders. This can be done by "mailbox stuffing," visits, and other means. Thus the specialist can "plant seeds" among agents; the agent in turn can "plant seeds" among local people. Throughout the process, care must be taken to guard against having people do things "for us" rather than for themselves.

3. Provide teaching ideas and materials for agents and leaders. Stories of other communities are often motivating and help one as guides.

4. Provide definite help for program planning. Guide sheets, suggestions of State groups or other material to help communities in their health planning may be useful. Do this at an appropriate time before program planning time. Do this through State planning groups first insofar as you know them.

5. A newsletter to agents or to community club health leaders.

6. The health education specialist needs to know as much as possible about community population data, health status, socioeconomic conditions, organizations, and disorganization.

7. Help communities or counties carry out plans. Show follow-up interest by mail or other contact.

8. Health education specialist does not lead people to depend on him but rather encourages and helps them to be self-dependent and to get satisfaction from getting facts for themselves and working out their own solutions to their own problems.

9. The specialist avoids damaging family and community pride by pointing out what is wrong; he helps them to recognize what they have accomplished or have available and to build on it.

10. The specialist avoids pushing a project--he focuses on developing people.

11. Overorganization needs to be avoided; every community has many skeletons of organization lying around that are no longer effective.

12. Encourage and aid the use of community approaches in health and safety education whenever practicable. Through them it is often possible to reachpersons not otherwise reached so well, especially men as well as teaching againthose already reached. Good community appraoches to use are the already existing community activities in which health exhibits, demonstrations, and other teaching can be included. For example:

    (a) Community and county fairs
    (b) 4-H Achievement Days
    (c) Farm and home tours
    (d) County play days
    (e) Window displays during special campaign weeks
    (f) Other events

For health program development purposes, the community may be defined as the area or place in which there is the highest concentration of interest. In Clinton County, survey activity started with the smallest unit — the township. In some places it was the school district, breaking down a single township into two or three parts.

Among the methods and tools suggested for stimulating interest and discussion or for encouraging community activity were the following:

1. Health chairmen of each community improvement club might be invited to county meetings.

2. Check sheets, films, flip charts, and other means may be used to set off discussion. Each of these tools has dangers. The film may be primarily entertainment rather than used to introduce subject matter or to show a way to do something. The check sheet or the flip chart may narrow people's thinking so that they do not get down to "brass tacks" of problems in their own community.

3. Capitalize on illustrative cases wherever possible. For example, in one community a man who has had brucellosis is now the best advocate for pasteurization of milk.

4. Never prolong a meeting until interest lags. Let people's interest determine a meeting's length.

5. Avoid the "tell 'em" approach or the "let them pool their ignorance" approach. Guard against the possibility that even when the specialist's knowledge is pooled with that of local people, it is still a case of "pooled ignorance." Make use of resources available to provide information and assistance.

   Present facts; present ideas for procedures if needed, help lead the group to definite actions; help summarize the meeting by pointing out accomplishments.

SESSION V - MORE FODDER FOR OUR PART ON THE TEAM - TEACHING OUTLINES

The purpose of this session was to permit the group to work out teaching outlines for subjects of their own choosing. From the list given, the group selected 5 major subjects for problem areas, and then divided into 5 groups as desired to work on these topics. These topics and the outlines worked out for each were: 1/

Subjects	Outlines Include
Accident prevention	Teaching objectives
Brucellosis	Subject ideas and facts to be stressed
Community health	Suggestions for demonstrations and visual aids
Mental health	Suggestions for mass media
Weight control	Sources of information
	Procedures for a leader-training meeting

SESSION VI - WORKING TOGETHER AS A TEAM

A. Using State Departments of Health in Extension Health Education

The need for integration and coordination of effort in rural health improvement had been brought out a number of times in the course of the preceding discussions. Many interests are involved, and many professional workers, sometimes competing rather than cooperating with each other. Ideas and examples of working together with the State departments of health were brought out by the discussion and reports from States, as follows:

Iowa

The summer health workshop is sponsored by a number of health groups, including the health department, extension service, education, nursing, health improvement associations, and others. The county health-improvement associations have a small budget raised by a special fee of 50 cents to $1 per member per year. About 20 county associations sponsored a representative at the workshop last year. County farm bureaus, the cancer society, and other groups have done likewise. The workshop is for local public health workers and lay leaders interested in rural health improvement.

Nebraska

The nutritionist in the State health department started a diabetic camp. Every county was given the privilege of sending one or more diabetic children. Extension and 4-H Clubs paid the way for 12 children at $30 each.

The physical proximity of the health department and extension, both being in Lincoln, makes cooperation easy. The health department has asked Extension's cooperation. The sanitarian is now working with the health education specialist on a pamphlet, Health Hazards in Community Feeding. This will be useful to 4-H camps, churches, and other groups.

1/ These teaching outlines are available as separates

Pennsylvania

Had the sanitarian from the State health department help on camp sanitation and feeding for statewide leader training camp.

Mississippi

Eight counties have health educators in local public health unit. They are called on to work hand in hand with leaders in home demonstration and 4-H. Public health is now seeing the many channels extension can open to them.

A statewide meeting on community health planning brought together representatives of the Extension Service, State PTA, Public Health, medical association, State nurses' association, health educator, State health chairmen for home demonstration clubs, director of child welfare, and others. Working together in this way, each agency is learning how to better serve rural people. Extension has facilitated this learning.

The welfare department recently appointed a nutritionist to work with low-income people who have not been reached by extension and public health. We are not reaching these people well enough, and the welfare department does not know how to reach them, either.

At first we had to develop the attitude that everyone had a part to play; that no one group could do it all. Previously many services operated in competition with each other; usually lack of information about what was going on was the chief reason.

The panel discussion on community health planning led to avoiding duplication of nurse recruiting activity, obtained support for a State planning group, and developed cooperation along other lines.

Nurses and sanitarians have training meetings. They need to be calling in extension people from the counties for these meetings.

Arkansas

The extension health education specialist is a good public relations person for the extension staff. In Arkansas in 1946 many health people did not know about extension. The gap between public health and extension was immense. This situation has been greatly improved. Our State rural health conferences have helped this. We have also worked jointly in leader-training meetings, water-testing demonstrations, and the like. We use their materials a good deal.

Illinois

Bringing in the health department, county veterinarian, representatives of cancer society, health association, Red Cross, and other groups helps greatly in interpreting to these people what extension is doing. It also makes a leader-training school much more effective through helping local people to understand the use of local resources. Before leader-training meetings are held, I ask the county home adviser to invite in the county health nurse or some such person if there is a county health department, and this has worked

very successfully. The county home advisers now do it voluntarily, and are beginning to use them in their program planning as well, and also in the local unit meetings.

Georgia

A home demonstration council met about 3 years ago to discuss local problems. They were trying to get immunizations for school children. The health education specialist discussed services of a local health unit and suggested inviting in the regional nurse consultant, health officer, and county supervisors. The group also got the cooperation of the Farm Bureau and civic groups. They went together and made definite plans for a health unit. The home demonstration council assumed responsibility for providing equipment. Each club took a responsibility including painting the office space. They could not get funds enough for secretarial help for the nurse so the women volunteered to meet with her on a rotating basis to assist her with clinics. As a result of these efforts, local people feel that the health unit belongs to them, and they are using its services.

In other counties where they have had the unit for 20 or 25 years, the average home demonstration leader knows little about its services or how to use them. In general, public health works with programs; extension works with people and their problems. Often as extension workers we should take the lead in using public health people as a resource. A little joint work here and there on a specific subject will establish acquaintance and lay a basis for further cooperation.

Nebraska

We have had a weak public health organization, more or less a political football. Extension has been able to promote the strengthening of the organization. For four sessions of the State legislature, it has been instrumental in gaining the support of a number of groups for a bill to form a State board of health with lay representatives on it. Within the last 6 weeks the bill was passed. The board will include two doctors, a veterinarian, a dentist, and two lay people.

Florida

We have invited the participation of the State board of health in our annual agents' conference. An exhibit has been set up on knowing and using your county health department. Extension agents are beginning to see how they fit in. Before, we had the problem of lack of understanding. Our State extension nutritionist could not understand why the State board of health had employed a nutritionist.

Iowa

Who has any vested rights? The health department has the official job of looking after the health of all the people in the State. They are the official agency and we work with them in reaching as many people as possible.

North Carolina

We have a very good working relationship with the public health department. In some areas there is a lack of information on what another agency is doing. We call on public health people for subject matter. In home nursing, we suggest to the agent that they get the county nurse to give the demonstration. The nurse, sanitary engineer, nutritionist, and others may be called in on county health planning. We have no hesitation in calling on them and they do the same thing with us.

Michigan

Relations between extension and the health department have been good. Recently the extension specialist was asked to cooperate in a workshop for public health people. We had an initial problem -- the health educator was concerned about the job of the health education specialist in extension. Actually much of the public health education is carried on by nurses, sanitarians, and others. Extension tries to facilitate the process.

Florida

Before the health education specilist was hired, extension wrote to the State medical association and the State health department to explain the matter and invite cooperation. Every 3 months there is an interagency workshop at the health department in Jacksonville for 3 days of training and getting acquainted with the health department. We now have close cooperation between the two agencies. These relationships should be started before the new specialist comes on the job.

Oregon

We did the same thing. Extension directors had a conference with the State health director before hiring a specialist. This initial contact is important. The State health council involving cooperation of public health, extension, and other groups has brought everyone together. At the county level we have always used as resource persons the health officer, nurse, and others from the local health unit. We have good relationships but we have to make 75 percent of the effort.

Wisconsin

The State board of health prepares material for us. We work together in planning it. Home demonstration guide material, for example, includes information on the State board of health, State medical society, 4-H, and other groups.

Summary - Mr. Guy Dowdy of Ohio.

Our philosophy is colored by our own situation. The State department of health, in general, services its own organization. The State departments of welfare and education, likewise, service their organizations.

Extension Service services the rural people. This is a different concept. These other organizations look to extension to take leadership in organizaing rural people - opeing channels to them. Extension's responsibility is to "organize" or otherwise help rural people.

1. To study their local situation and get the facts.
2. To discover what their problems are.
3. To decide what to do and when.
4. To marshal the available resources whether local or from outside.
5. To carry through on these programs.
6. To evaluate their activities.

In this process, extension is servicing people. The Extension Service cannot solve the people's problems but it can help them to solve their own problems by this process. The Extension Service must have breadth of vision, a kit of techniques, patience, resourcefulness, optimism, and diligence to help people lift themselves by their own bootstraps. Most of all this involves building and keeping working relations between Extension and other resources and programs. This is what we are already doing pretty well, as indicated by reports from various States.

B. Ways of Reaching the Men of Rural Families with Health Education

Ways and means of bringing the whole family into the Extension health program was a topic dealt with briefly. Suggestions included:

Community meetings of family groups.

Home demonstration club meetings to which men were invited and where a meal might be served.

Farm and Home Week programs.

Personal appeal of such programs as brucellosis control--every man in Nebraska was said to know at least one person suffereing from brucellosis.

Stress the economic aspect; it often appeals to men and influences them.

Using a team made up of both men and women in dealing with such problems as farm and home sanitation and animal diseases transmissible to man.

Including health in county overall program planning or agricultural planning with suggestions of program possibilities and with background material furnished to local agents as they canpresent it to the farmers groups.

County 4-H awards and camp programs which include safety and sanitation.

Inclusion of health in annual State staff conferences; have demonstations to show how health fits into program.

Getting the health department to make it known to local agricultural extension agents that they are essential in a health program.

Convincing extension agents that health is part of the welfare of the people and furnishing them materials and helps that they can apply.

Extension agent committees to tell specialists what they want.

Case studies such as that of Clinton County illustrating the involvement of 4-H Clubs in testing water supplies throughout the county; assigning other responsibilities in health to 4-H members and demonstrating to this younger group the responsibility of the family and the community for their own health; avoiding giving clubs chores -- instead, including them in planning. (Programs by 4-H Clubs are one means of involving adults.)

Community approaches as previously mentioned (page 19)

The basic principle is to involve in the health and safety education men at every opportunity. Don't miss a bet to do so. Reach especially the agricultural agents; next in importance are farm leaders.

C. Special Reports

Report of APHA meeting at Cleveland. A brief report of the APHA meeting commented on the very large number of professional and lay persons attending, the value of the exhibits, the rather general practice of reading speeches. Some of the sections, however, deviated from this practice. Discussion proved much livelier in the more relaxed atmosphere, and there was more value in much of the subject matter presented.

The National 4-H Health Committee. A report from this committee raised questions regarding awards -- how to set them up in order to achieve desired results, how to give recognition to boys and girls, whether recognition should be on district and county levels, and how to appeal to youngsters in order to develop interest in a health program. The need was commented on for evaluation of long-term projects in some States in order to learn what might be applied elsewhere, especially toward incorporating health in all projects rather than setting up health clubs. It was suggested that a workshop might be held to go into these questions more thoroughly.

Great Plains Health Study. The 6 States of the Northern Great Plains have developed a health study through a committee on the Northern Great Plains Council. A general plan and tentative schedule were developed at a meeting in August in Lander, Wyo. Dr. Niederfrank, A. H. Anderson of the BAE, and Dr. Hoyle, of the U.S.Public Health Service, participated in the refinement of the schedule. Each State will compile its own report in addition to the overall report of health and medical care facilities for the six States. Local data on health facilities, services, and problems are being obtained from every county in the six States by a questionnaire filled out by a leaders' group sitting as a committee under the leadership of the county agents. Numerous reports have been received about how this

has already started some education on health improving activies; the survey had stimulated interest and group action. The information will be useful later in county program planning. A first preliminary report on findings will be presented at the 1953 meeting of the Great Plains Health Committee meeting August 1 and 2, at Laramie, Wyo.

Suggestions for Next Year

The Steering Committee, under chairmanship of Helen Becker, made its report, which was discussed, and the following recommendations were agreed upon.

1. Ask approval of Extension Organization and Policy Committee for another conference next year, in conjunstion with the AMA Rural Health Conference, which is scheduled for Dallas, Tex., Thursday to Saturday, March 5 to 7.

2. Have extension conference before the AMA conference instead of afterward, in order to permit attending both and being away from home only 1 work week. This would make the extension conference March 2-4.

3. Program to concentrate on method subjects like readability and leader-training meetings, and give less proportionate attention to topics on general relations, community organization and subejct matter. Instead of each State giving an overall summary of its work, concentrate on describing one specific thing more fully.

4. Program cochairman for the next year to work with Dr. Niederfrank: Mrs. Annette Boutwell, Mississippi.

5. Group urged the voluntary exchange of materials and outlines for demonstrations, teaching outlines and other materials, among one another; and that a copy of new materials be sent to the Federal office.

The conference adjourned at noon, March 4.

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Movies at Conference

The following movies were shown or referred to at the conference in order to give any attending the conference an opportunity to learn about films which they had not seen before:

1. Losing to Win (Cheers for Chubby). (Weight control.) Metropolitan Life Insurance Co., New York. Available from State departments of health.

2. Drop in the Bucket. (Fluoridation.) U.S.Public Health Service. Available from State departments.

3. Doorway to Death.(Home safety.) Aetna Life Insurance and Casualty Companies. Available from district offices.

4. Welton: A Healthy Community. (Work of a local public health department.) Department of Visual Aids, University of Washington, Seattle 5, Wash.

5. The Farmer and the Telephone. (A doctor helps a county get a telephone system as a health facility.) Rural Electrification Administration, USDA, Washington 25, D.C.

6. Obesity: Problems of Fat Formation and Overweight. Available from Encyclopedia Brittanica, Inc., Wilmette, Ill.

7. Mental Health. (Good general description.) Encyclopedia Brittanica, Inc., Wilmette, Ill.

8. Miracle in Paradise Valley. (Farm safety.) Sinclair Oil Refining Co. Available from district offices.

9. Out of True. (Family mental health situation — very good.) Canadian Film Board, British Information Service. Available from International Film Service, 57 East Jackson Boulevard, Chicago 4, Ill.

10. So Much for So Little. (Very good on what a local public health department is.) U.S.Public Health Service and State departments of health.

11. The Walking Machine. (Very good on feet and health.) American Foot Care Institute. New York.

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